

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13102

Reg. Dist. No. 13

13\*32

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>8 Sunset Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EARL</b>	Middle <b>ABRECHT</b>	4. DATE OF DEATH <b>December 26, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 18, 1895</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <b>62</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic U.S. Govt. Automobiles</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George F. Abrecht</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Esterly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9187</b>	
17. INFORMANT <b>Same as above</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		Coronary Thrombosis	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>(b)</b>			
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Dec. 26, 1957</b>
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>	22a. BURIAL, Cremation, Removal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 26, 1957</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
24a. REC'D BY REGISTRAR DATE <b>27 Dec. 1957</b>		24b. REGISTRAR'S SIGNATURE DATE <b>Elizabeth L. Heck</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Please 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X.

DEC 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13105

## CERTIFICATE OF DEATH

13103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print)		First	Middle
Raymond		Alexander	Allen
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 23-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick-Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Henry Allen		14. MOTHER'S MAIDEN NAME Mary Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-0308	
17. INFORMANT		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Acute Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Delerium Tremens (c)		10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from Dec. 15, 1957, to Dec. 23, 1957, that I last saw the deceased alive on Dec. 23, 1957, and that death occurred at 2 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard D. Hinman		ADDRESS (Street, city or town, state) Frederick, Md.	
DATE SIGNED Dec. 26, 1957			
PHYSICIAN'S NAME (Type) B.O. Thomas Jr.		Professional Building Frederick, Md.	
22a. BURIAL/CREMATION- REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26-57	22c. NAME OF CEMETERY OR CREMATORIUM Fairview	22d. LOCATION (City, town, or county) (State) Frederick Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III		ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE 26 Dec. 1957
			24b. REGISTRAR'S SIGNATURE Elizabeth L. Hock

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BRUNAU V.

DEC 27 1960

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13133

## CERTIFICATE OF DEATH

Reg. Dth. No. 13104

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 50 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Frederick MARYLAND		Rural—Thurmont				a. STATE Maryland b. COUNTY Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		rural Thurmont		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Annie		Mary	Anders		December 16	19	57			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY?			
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 11, 1883	74 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housewife		Own home		Pennsylvania		U.S.A.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
John H. Roof				Mary Catherine Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		None		James H. Anders		Thurmont, Md. RD 1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN DUE TO <u>434.1</u> ONSET AND DEATH <u>3 mos.</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>Sept. 15, 1957</u> to <u>Dec. 16, 1957</u> that I last saw the deceased alive on <u>Dec. 13, 1957</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.									ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <u>James K. Gray</u>		M.D.		Thurmont—Md.				DATE SIGNED <u>12/16/57</u>		
PHYSICIAN'S NAME (Type) <u>Dr. James K. Gray</u>				Thurmont—Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-19-57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Lewistown Cemetery</u>		22d. LOCATION (City, town, or county) <u>Lewistown, Maryland</u>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
				DATE <u>DEC 19 57</u>		Signature <u>Alt. Leach</u>				

DESTRUCTIVE DEATH

BUREAU X-1

DEC 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

Items 20&21 Film 224 1-15-70 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson—Rural</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>3 mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson—Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas Larry Barnhouse</b>		First	Middle
4. DATE OF DEATH <b>December 30 1957</b>		Last	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 24-1943</b>
9. AGE (In years last birthday) <b>14 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Carroll Barnhouse</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Best</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr Carroll Barnhouse, Dickerson, Rt. 1—bd</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>929.9</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Grocery Accidental</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>#</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Wade in the river after a boat Went in deep water &amp; drowned.</b>	
20c. TIME OF INJURY Hour <b>4:30 p.m.</b>	Month, Day, Year <b>12-30 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mr. Dickerson Frederick Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <b>10-2-58</b>	
ACTUAL SIGNATURE <i>Bo Theszel</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. Theszel</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>No. 700 Cacy</b>		22d. LOCATION (City, town, or county) <b>Beallsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville Md</b>		24c. REC'D BY REGISTRAR <b>1/6/58</b>	24d. REGISTRAR'S SIGNATURE <b>A. H. Hedrich</b>

RECEIVED  
BUREAU V. S.

JAN 7 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13:06

## CERTIFICATE OF DEATH

13108/

Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
Frederick MARYLAND		a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick					
Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 11 Dickerson					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Wanda Jean Barnhouse		First	Middle				
4. DATE OF DEATH		Month	Day				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday) 17 Feb 57 yrs. 10	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carroll Barnhouse		14. MOTHER'S MAIDEN NAME Rachel Best		Address Dickerson, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mother		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 DUE TO Mucoviscidosis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO 756.2				INTERVAL BETWEEN ONSET AND DEATH 5 Mo	
DUE TO 756.2							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 Dec 1957 to 25 Dec 1957, and that death occurred at 220 M, from the causes and on the date stated above. ACTUAL SIGNATURE						ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) A. M. Powell, Jr. M.D.						26 Dec 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) Bealeville (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR DATE 12/28/57		24b. REGISTRAR'S SIGNATURE Charlotte Elsey Elsey Neck, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA  
DEPARTMENT OF JUSTICE  
CERTIFICATE OF DEATH

BUREAU V. 2

DEC 30 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**13135 CERTIFICATE OF DEATH**

13107  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
c. LENGTH OF STAY IN 1b <b>35 yrs</b>		d. STREET ADDRESS <b>Altamont Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Haidee</b>		First <b>V.</b>	Middle <b>Beard</b>
4. DATE OF DEATH <b>December 4 1957</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Dec. 19, 1884</b>	8. AGE (In years last birthday) <b>72 yrs.</b>
9. IF UNDER 1 YEAR Months <b>0</b>		10. IF UNDER 24 HRS. Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b>		12. IF UNDER 24 HRS. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public school</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>M.L. Beard</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Mrs. Lester Birely</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <b>Hypertension</b>		2 years	
DUE TO  (c) <b>Arteriosclerosis</b>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 2, 1957</b> , to <b>Dec. 4, 1957</b> , that I last saw the deceased alive on <b>Dec. 4, 1957</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE  <i>M. Franklin Birely</i>		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>12/5/57</b>	
NAME (Type) <b>M. Franklin Birely</b>		Thurmont, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-6-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Middletown Luthern Cem</b>		22d. LOCATION (City, town, or county) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>Raymond E. Creager</i>		ADDRESS <b>Thurmont, Maryland</b> DATE <b>Dec. 5, 1957</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Raymond E. Creager</b>	

EDWARD V. S.

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EDWARD V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13107

## CERTIFICATE OF DEATH

13108  
131

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		b. COUNTY <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>321 Catoctin Ave.</b>		d. STREET ADDRESS <b>321 Catoctin Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>William</b>	Last <b>Bennett</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>28</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>12-13-1885</b>
8. AGE (In years last birthday) <b>72 yrs</b>	9. IF UNDER 1 YEAR Months <b>0</b>	10. IF UNDER 24 HRS Days <b>0</b>	11. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Burdette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-18-1723</b>	17. INFORMANT Address <b>Mrs. John W. Bennett-321 Catoctin Ave.-Frederick</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause if lost.			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1956</b> , to <b>Dec. 28, 1957</b> , that I last saw the deceased alive on <b>Dec. 28, 1957</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 East Church St.</b> DATE SIGNED <b>12-30-57</b>			
ACTUAL SIGNATURE <i>Rex R. Martin</i>		M.D. <b>Frederick-Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-31-1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Pine Grove Cemetery</b>	22d. LOCATION (City, town, or county) <b>Mt. Airy-Maryland</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		ADDRESS <b>Frederick-Maryland</b>	
VS A15 (4) 15M 9/55		24a. REC'D BY REGISTRAR <b>DATE 12-31-1957</b>	24b. REGISTRAR'S SIGNATURE <b>Ely G. Schick</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13136

## CERTIFICATE OF DEATH

13109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Fredrick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham		c. LENGTH OF STAY IN 1b 3 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham				
3. NAME OF DECEASED (Type or print) Otto		4. DATE OF DEATH December 16 1957				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1897			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ford Company		10b. KIND OF BUSINESS OR INDUSTRY Assembly worker				
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles M. Boller		14. MOTHER'S MAIDEN NAME Effie M. Firor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) Yes		16. SOCIAL SECURITY NO. WORLD-WAR 1 370-07-5932	17. INFORMANT Raymond Boller			
		Address Graceham, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 13 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from Oct. 1—, 1957, to Dec. 16—, 1957, that I last saw the deceased alive on Dec. 11—, 1957, and that death occurred at 9 A. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Thurmont - Md.						
ACTUAL SIGNATURE Dr. James K. Gray			DATE SIGNED 12/16/57			
22a. BUR AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DEC 19 1957	24b. REGISTRAR'S SIGNATURE Ole Leinen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13108**      **CERTIFICATE OF DEATH**

1310

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
FREDERICK MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b lifelong	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	
VINDOBONA CONVLESENT HOME		d. STREET ADDRESS BRADDOCK HEIGHTS MD.	
3. NAME OF DECEASED (Type or print)		First	Middle
CLARA M. WILCOXIN			BROWN.
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9. DATE OF BIRTH	
		Mar. 12, 1863.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Andrew Jackson Wilcoxin.		Anna Mary Getzendanner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		220-10-5138	
17. INFORMANT		Address	
Husband's Number		Miss. Anna W. Brown, Daughter.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 weeks	
181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		infection	
(b)		Senility	
DUE TO		Carcinoma of Bladder.	
(c)		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
411X Cronic Pulmonary			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 14</u> , 1957, to <u>Dec 15</u> , 1957, that I last saw the deceased alive on <u>Dec 14</u> , 1957, and that death occurred at <u>1245 N</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>H. L. Fahrney</i>		M.D.	
PHYSICIAN'S NAME (Type)		FREDERICK MARYLAND.	
22a. BURIAL, CREMATION, REMAINT (Specify) BURIAL		22b. DATE THEREOF DEC. 17, 1957. Mt. Olivet Cemetery	
22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county) FREDERICK, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Fahrney</i>		ADDRESS DAILEY'S FUNERAL HOME FREDERICK, MARYLAND.	
24a. REC'D BY REGISTRAR DATE 18 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove carbon paper. Pages 2 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13111

13109

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY	
c. LENGTH OF STAY IN 1b 40 yrs.		Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home-708 N. Mkt. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie E. Brunner		First Middle Last	4. DATE OF DEATH Dec. 17 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>
8. B. DATE OF BIRTH Nov. 26-1884		9. AGE (in years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Weddle		14. MOTHER'S MAIDEN NAME Rebecca Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Margaret A. Brunner-627 Park Place-		Address Frederick-Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 wks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Generalized arteriosclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Dec 18</u> , 1957, that I last saw the deceased alive on <u>Dec 18</u> , 1957, and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas E. Stone</u>		M.D. <u>4 West Third St.</u>	
PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-1957	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		24a. REC'D BY REGISTRAR DATE 21 Dec 1957	
W. ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE Elisabeth G. Hesch	

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DEC 26 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13112

## 13137 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Frederick		
b. CEMETOR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 30 years		c. CEMETOR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First A.	Middle .	Last Bussard	4. DATE OF DEATH 12	Month Dec	Day 8	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1893	9. AGE (in years last birthday) 63 yrs	10. IF UNDER 1 YEAR (IF UNDER 24 HRS Months Days Hours Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mech. engineer		10b. KIND OF BUSINESS OR INDUSTRY ice cream plant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles A. Bussard			14. MOTHER'S MAIDEN NAME Minnie Gaver					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO 212-10-8229		17. INFORMANT Mrs. Nannie Bussard, Middletown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute coronary occlusion</i> INTERVAL BETWEEN ONSET AND DEATH 5-10 min. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arteriosclerotic Heart disease</i> 5-6 years DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m.		Month Dec 19	Doy .	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County)	(State)
21. I certify that I attended the deceased from <i>Dec 5, 1957</i> , to <i>Dec 8, 1957</i> , that I last saw the deceased alive on <i>Dec 5, 1957</i> , and that death occurred at <i>11:55 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL <i>Kenneth C. Henson</i> M.D. <i>Middletown, Md.</i>								
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson Middletown, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/1957		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.			24a. REC'D BY REGISTRAR DATE 13 Dec 1957 24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck					

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13110

## CERTIFICATE OF DEATH

13114  
(13114)

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 45 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 120 East Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS		First	Middle	Last	4. DATE OF DEATH CARTNAIL	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 May 1896	9. AGE (In years (by birthday) 61 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dray Truck		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Cartnail			14. MOTHER'S MAIDEN NAME Hester Palmer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-10-0699		17. INFORMANT Mrs. Emma Cartnail (Same as item #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			Carcinoma of prostate with metastasis			INTERVAL BETWEEN ONSET AND DEATH 1 - 2 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 35 E. Church St., Frederick, Md.	(County) 12-16-57	(State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Dec 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 35 E. Church St., Frederick, Md. DATE SIGNED ACTUAL SIGNATURE <u>Rex R. Martin</u> 12-16-57									
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 18 Dec 1957		24b. REGISTRAR'S SIGNATURE Eligabeth B. Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13115

## 13138 CERTIFICATE OF DEATH

Reg. Dist. No 141

1. PLACE OF DEATH a. COUNTY <b>FREDERICK-BRUNSWICK MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		c. LENGTH OF STAY IN 1b <b>1b</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brunswick MD.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First	Middle
		<b>HENRY</b>	<b>CRAYER</b>
4. DATE OF DEATH		Month	Day
		<b>12</b>	<b>3</b>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
<b>MALE</b>		<b>WHITE</b>	<b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>12-27-1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM LABOURER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
			<b>HARMONY-GROVE U.S.A.</b>
13. FATHER'S NAME <b>CHARLES E. CRAYER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA E. POWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT
			<b>HARRY W. WOLF-BRUNSWICK MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
DUE TO <i>Atherosclerosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.
			20f. (City or town) <b>UTICA</b> (County) <b>MD.</b> (State)
21. I certify that I attended the deceased from <b>12/12/57</b> to <b>12/27/57</b> , that I last saw the deceased alive on <b>12/12/57</b> , and that death occurred at <b>12/27/57</b> M.D., from the causes and on the date stated above. ACTUAL SIGNATURE <i>John D. Feeter</i>		ADDRESS (Street, city or town, state) <b>13138</b> DATE SIGNED <i>12/27/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-6-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>UTICA CEMETERY</b>
			22d. LOCATION (City, town, or county) <b>UTICA</b> (State) <b>MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Feeter</i>		ADDRESS <b>Brunswick MD.</b>	24a. REC'D BY REGISTRAR DATE <b>12-8-57</b> REGISTRAR'S SIGNATURE <i>Engeniora B. Brubaker</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 2 and 2 should be filed with  
the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13139 CERTIFICATE OF DEATH 13116  
Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE c. COUNTY <i>Maryland</i> <i>Frederick</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick, Md</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick, Md</i>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	d. STREET ADDRESS <i>119 N. 6th Ave.</i>	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <i>DINTERMAN JOHN C.</i>	4. DATE OF DEATH <i>DEC. 25</i>	Month <i>Dec.</i> Day <i>25</i> Year <i>1957</i>										
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1890</i>	9. AGE (In years last birthday) <i>67</i> yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>	13. IF UNDER 24 HRS Min. <i></i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RAILROAD MAN</i>			10b. KIND OF BUSINESS OR INDUSTRY <i></i>			11. BIRTHPLACE (State or foreign country) <i>PEARL MARYLAND, U. S. A.</i>			12. CITIZEN OF WHAT COUNTRY? <i></i>			
13. FATHER'S NAME <i>JACOB M. DINTERMAN</i>			14. MOTHER'S MAIDEN NAME <i>RACHAEL LARE</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) <i></i>			16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>RAYMOND DINTERMAN</i>	Address <i>HAGERSTON</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b) DUE TO  (c) DUE TO  (d) DUE TO											INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Dec 23</i> 1957 p. m. <i></i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>			(County) <i></i>	(State) <i></i>		
21. I certify that I attended the deceased from <i>Dec 18, 1957</i> to <i>Dec 25, 1957</i> , that I last saw the deceased alive on <i>Dec 23, 1957</i> , and that death occurred at <i>3007</i> M, from the causes and on the date stated above.											ADDRESS (Street, city or town, state) <i>Rosemont, c/o Jules F. Langlet</i>	DATE SIGNED <i></i>
ACTUAL SIGNATURE <i>Jules F. Langlet</i>		PHYSICIAN'S NAME (Type) <i>JULES F. LANGLET</i>		22d. LOCATION (City, town, or county) <i>Brunswick, Md</i>							(State) <i></i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-28-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Park Heights</i>		22d. LOCATION (City, town, or county) <i>Brunswick, Md</i>					(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elva V. Teete</i>		24a. REC'D BY REGISTRAR <i>Brunswick, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Eugenia H. Burke</i>								
DATE <i>12-29-57</i>				DATE <i>12-29-57</i>								

EDWARD V. S.

DEC 6 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13111 CERTIFICATE OF DEATH

13117

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE BURKITTSVILLE Maryland, COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BURKITTSVILLE		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURKITTSVILLE, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		d. STREET ADDRESS (RURAL)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Louise	Last Dorsey	4. DATE OF DEATH 12	Month 6	Day Year 1957	
5. SEX F	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5 1916	9. AGE (In years last birthday 41 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BURKITTSVILLE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS SPRIGGS		14. MOTHER'S MAIDEN NAME HATTIE BUTLER		Address KATHERINE F. SPRIGGS, BURKITTSVILLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT KATHERINE F. SPRIGGS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Rheumatic Heart disease (c)	INTERVAL BETWEEN ONSET AND DEATH 2 weeks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 490 Tuber pneumonia		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24, 1957, to 12/6/57, that I last saw the deceased alive on 12/5, 1957, and that death occurred at 12:26 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Henry V Chase PHYSICIAN'S NAME (Type) Henry V. Chase		ADDRESS 4 E. Church St Frederick Md.		ADDRESS (Street, city or town, state) PETERSVILLE, Md.		DATE SIGNED 12/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 9	22b. DATE THEREOF Dec. 9	22c. NAME OF CEMETERY OR CREMATORIUM Catholic Cemetery St. Mary	22d. LOCATION (City, town, or county) PETERSVILLE, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Elva L. Tice	ADDRESS Burkittsville, Md.	24a. REC'D BY REGISTRAR DATE 12-9-57	24b. REGISTRAR'S SIGNATURE Eugenia F. Burch				

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13112

## CERTIFICATE OF DEATH

13118  
731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		Detour rural	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
50 days		1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Frederick Memorial			
3. NAME OF DECEASED (Type or print)		First	Middle
Lura Irene		Last	
4. DATE OF DEATH		Month	Day
Dougherty		12	12
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	8. DATE OF BIRTH
9. AGE (In years last birthday)		9. IF UNDER 1 YEAR IF UNDER 24 HRS.	
69 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Own home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Frederick CO		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jacob Flickinger		Emma Hildebrand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Mr. Baxter C. Dougherty	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		Congestive heart failure	
DUE TO		1 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Anemia	
DUE TO		3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1. Fracture of left femur 2/6/57			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11 1 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Home		Detour Md.	
21. I certify that I attended the deceased from 11/7/57 to 12/22/57, and that death occurred at 5:30 A.M. on 12/21/57, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
Henry L. Chase M.D.		12/22/57	
PHYSICIAN'S NAME (Type)		Henry L. Chase Frederick Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-25-57	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Mt. Zion Cemetery		Haugh's nr. Ladiesburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
Raymond E. Creager		Thurmont, Maryland	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Thurmont, Maryland		Elly Shockey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the reg. office prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 131194

13:13

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>25 Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>213 Delaware Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Bertha Lee Eddins</b>		4. DATE OF DEATH <b>12 5 1957</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Oct 28 1895</b>	9. AGE (In years last birthday) <b>66 62rs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Augusta County, Va.</b>
13. FATHER'S NAME <b>DAVID LANDES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET - FIFFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>LUCILLE PORTER, Rosemont</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malignant melanoma with metastases</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) <b>—</b> (State) <b>—</b>	
21. I certify that I attended the deceased from <b>11/25 1957</b> to <b>12/5 1957</b> , that I last saw the deceased alive on <b>12/5 1957</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL NATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <b>4 E. Church St 12/6/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Sec. 8, 1957</b>		22b. DATE THEREOF <b>Dec. 8, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Park Heights</b>		22d. LOCATION (City, town, or county) <b>Brunswick</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elva V. Teeter</b>		24a. ADDRESS <b>Brunswick Md.</b>	24b. REC'D BY REGISTRAR <b>Engle</b>
VS A15 14 15M 9/55		DATE <b>12-8-57</b>	

## Time

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13120

## 13114 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>FREDERICK</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>FREDERICK</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FREDERICK - Rural RD#3</i>		d. STREET ADDRESS <i>RT # 3 Bloomfield</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>FRED. MEMORIAL HOSP.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>STEVEN</i>		First	Middle <i>Douglas</i>	Lost	4. DATE OF DEATH <i>DEC. 19</i>	Month <i>DEC.</i>	Day <i>19</i>	Year <i>1957</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <i>10/3/56</i>	9. AGE (In years last birthday) <i>1 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>GRAYSON FISHER</i>		14. MOTHER'S MAIDEN NAME <i>JESSIE SPANGLER</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Grayson L. Fisher (Same as item #2)</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC FAILURE</i>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>(GENERALIZED) RETICULOENDOTHELIOSIS</i>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>10/3/56</i> , 19 <i>56</i> , to <i>12/19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/19</i> , 19 <i>57</i> , and that death occurred at <i>SP. M.</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>F. J. Heldrich</i> ADDRESS (Street, city or town, state) <i>220 N. Market St., Frederick, Md.</i> DATE SIGNED <i>12-19-57</i>								
PHYSICIAN'S NAME (Type) <i>F. J. Heldrich, M. D.</i>		22b. DATE THEREOF <i>12-21-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Frederick, Maryland</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>21 Dec 1957</i>		
						24b. REGISTRAR'S SIGNATURE <i>Elizabeth Heck</i>		

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13115 CERTIFICATE OF DEATH

13121

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown—Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Near Doubs	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CAREY	Middle WEBSTER	Last FITZE
4. DATE OF DEATH	Month December	Day 26	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 31 Jan 1956
9. AGE (In years last birthday) 1 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer T. Fitze		14. MOTHER'S MAIDEN NAME Helen Stine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elmer T. Fitze (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema		3 1/2 da	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. (b) cardiac arrest		3 1/2 da	
DUE TO (c) Pt induced cerebral hernia		3 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/29</u> , 1957, to <u>12/26</u> , 1957, that I last saw the deceased alive on <u>12/26</u> , 1957, and that death occurred at 8:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Frank S. Damazo, M.D.</u>		ADDRESS (Street, city or town, state) 7 W. 3rd St., Frederick, Md. DATE SIGNED 12-28-57	
PHYSICIAN'S NAME (Type) Frank S. Damazo, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-30-57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 30 Dec 1957	24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13122  
131

13116

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK CITY</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, NEAR MYERSVILLE</b>		d. STREET ADDRESS <b>MYERSVILLE FRED. CO. MD. R. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)  <i>M. H. F.</i>	First	Middle	Last	4. DATE OF DEATH <i>Flook</i>	Month	Day	Year		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 20 1871</b>	9. AGE (In years last birthday) <b>86</b> yr.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR BOONSBORO WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>SIMON SUMMERS</b>				14. MOTHER'S MAIDEN NAME <b>EMMALINE ZITTLE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>SAMUEL FLOOK MYERSVILLE MD ROUTE 1.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>32X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.  (b) DUE TO  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Cerebral Thrombosis</i>  <i>Generalized Arteriosclerosis</i>  INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> <i>6 months</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <i>Cerebral</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)  <i>4W 3 rd St</i>		(County)	(State)
21. I certify that I attended the deceased from <i>11-23</i> , 19 <i>52</i> to <i>11-16</i> , 19 <i>52</i> , that I last saw the deceased alive on <i>12-11</i> , 19 <i>52</i> , and that death occurred at <i>12 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state)  <i>4W 3 rd St</i>									
ACTUAL SIGNATURE  <i>J. Flook</i>	DATE SIGNED  <i>12-11-52</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 14 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) <b>BOONSBORO WASH. CO. MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>East Paul Flook Boonsboro Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>17 Dec 1957</i>		24b. REGISTRAR'S SIGNATURE  <i>Elizabeth S. Heck</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13117

## CERTIFICATE OF DEATH

13123  
131

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>131 East Third Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home for the Aged-115 Record St.</b>				d. STREET ADDRESS <b>115 Record St.</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Cora</b>	Middle <b>Freeman</b>	Last <b></b>	4. DATE OF DEATH <b>Dec. 2</b>	Month <b>Dec.</b>	Day <b>2</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRITAL STATUS WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1886</b>	9. AGE (In years last birthday) <b>71</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hrs <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper &amp; Dress Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. Diller</b>				14. MOTHER'S MAIDEN NAME <b>Annie Thomas Diller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>123-55-5567</b>		17. INFORMANT <b>Records-Home for the Aged-Frederick-Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute myocardial infarction (mild) Arterio-sclerotic heart dis. ?							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 18, 1957</b> to <b>Dec. 21, 1957</b> , that I last saw the deceased alive on <b>18 Nov. 1957</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>Charles H. Conley, Jr. M.D.</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>Dr. Chas. H. Conley-Jr.</b> <b>Frederick-Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick- Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Md.</b>		24a. REC'D BY REGISTRAR <b>Elizabeth G. Heek</b> DATE <b>4 Dec. 1957</b>	
24b. REGISTRAR'S SIGNATURE							

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13140 CERTIFICATE OF DEATH

13124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, RD 1		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 75 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaintdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Thurmont, RD 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Luther	Middle Thomas	Last Geesey
4. DATE OF DEATH	Month December	Day 27	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Geesey		14. MOTHER'S MAIDEN NAME Sophia Alice Shook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-2147	
17. INFORMANT Stella Geesey		Address Thurmont, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 months	
Congestive heart failure arteriosclerotic cardiovascular disease		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 1957, to <u>27 Dec 1957</u> that I last saw the deceased alive on <u>26 Dec</u> , 1957, and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>JAMES E. Stoner Jr</u> M.D. PHYSICIAN'S NAME (Type) <u>James E. Stoner Jr</u>		DATE SIGNED <u>28 Dec 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-57	
22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery		22d. LOCATION (City, town, or county) Lewistown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		24a. REC'D BY REGISTRAR DATE DEC 31 '57	
ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE <u>Al. eae</u>	

Y. A. M. U. N. I. A. N. D.

DEC 3, 1957

W. E. G. - 1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11

1-6-59 at

13118

## CERTIFICATE OF DEATH

13125

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial</i>		e. STREET ADDRESS <i>1112-1st Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Nellie</i>		First <i>B</i>	Middle <i>Gordon</i>
4. DATE OF DEATH <i>12</i>	Month <i>12</i>	Day <i>26</i>	Year <i>1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/21/08</i>
9. AGE (In years lost birthday) <i>49</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hrs <i>0</i>
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Brunswick, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>THOMAS WIGGINGTON</i>	14. MOTHER'S MAIDEN NAME <i>Bessie Metz</i>	Address <i>112-1st Ave.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	17. INFORMANT <i>JAMES R. GORDON</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), <i>Acute pulmonary edema</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b) Cancer of the breast with (c) Generalized metastases</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>	
DUE TO <i>Due to</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day Not while at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Brunswick</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>12/26</i> , 19 <i>57</i> , to <i>12/26</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/26</i> , 19 <i>57</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry V Chase</i>			
ADDRESS (Street, city or town, state) <i>4 E. Church St</i>			
DATE SIGNED <i>12/26/57</i>			
PHYSICIAN'S NAME (Type) <i>Henry V. Chase Frederick Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-29-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Park Heights</i>	22d. LOCATION (City, town, or county) <i>Brunswick Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elva V. Teeter Brunswick Md</i>	ADDRESS <i>12-29-57</i>	24a. REC'D BY REGISTRAR <i>Eugenia J. Burke</i>	24b. REGISTRAR'S SIGNATURE

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REGAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13126

13131

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>18 EAST "C" ST.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New ADDITION</b>		d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MVRTE - CECILIA - Gosnell</b>		First <b>M</b>	Middle <b>CECILIA</b>	Last <b>Gosnell</b>	4. DATE OF DEATH <b>Dec. 6 1957</b>	Month <b>Dec.</b>	Day <b>6</b>	Year <b>1957</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17 1887</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John</b>			14. MOTHER'S MARRIED NAME <b>JENNY Cooper</b>		Address <b>Brunswick, Md.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>EURLY Gosnell</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b> DUE TO <b>424.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>acute Congestive Failure</b> 5 yrs.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Brunswick, Md.</b>		(County) <b>-</b>	(State) <b>-</b>	
21. I certify that I attended the deceased from <b>March 1947 to Dec 6 1957</b> that I last saw the deceased alive on <b>12/6/57</b> , and that death occurred at <b>115 1/2 M</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W.H. Carpenter</b>		ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b>							DATE SIGNED <b>12/6/57</b>	
22a. BURIAL, CREMATION, <input checked="" type="checkbox"/> REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Knoxville Cemetery</b>		22d. LOCATION (City, town, or county) <b>Knoxville, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Eloa V. Teeter Brunswick, Md.</b>		ADDRESS <b>-</b>		24a. REC'D BY REGISTRAR <b>12-9-57</b>		24b. REGISTRAR'S SIGNATURE <b>Eugenia H. Bush</b>				

BUAUAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13127

13:41

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN 1b <b>1498 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>	
3. NAME OF DECEASED (Type or print) <b>Howard</b>		First <b>V.</b>	Middle <b>Green</b>
4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>9</b>	Year <b>1957</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/3/1902</b>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Green</b>		14. MOTHER'S MAIDEN NAME <b>Susan E. Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-09-8564</b>	
17. INFORMANT <b>Records of Victor Cullen Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 2, 1953</b> , to <b>Dec. 9, 1957</b> , that I last saw the deceased alive on <b>Dec. 9, 1957</b> , and that death occurred at <b>10:30A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cullen, Md.</b> DATE SIGNED <b>Dec. 9, 1957</b>			
ACTUAL SIGNATURE <i>T. F. Vestal</i>		M.D.	
PHYSICIAN'S NAME (Type) <b>T. F. Vestal</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-12-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Spindale Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Spindale, North Carolina</b>
22e. FUNERAL DIRECTOR'S SIGNATURE <i>M. C. Clegg, Esq., Funeral Dir.</i>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '57</b>	
		24b. REGISTRAR'S SIGNATURE <i>Alt. Seach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the record.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## 13:42 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL, JOHNSVILLE</b>		d. STREET ADDRESS <b>JOHNSVILLE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN PETER GREEN</b>	First	Middle	Last	4. DATE OF DEATH <b>DEC 18 1957</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>AUG 23-1872</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH OWN SHOP</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>PERRY GREEN</b>		14. MOTHER'S MOTHER'S NAME <b>ELLEN LONG</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN D GREEN JOHNSVILLE MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Myocardial Degeneration Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 0 days years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-15-1957</b> , to <b>12-18-1957</b> , that I last saw the deceased alive on <b>12-18-1957</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. N. Ligg M.D.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>12-18-1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Thomas H. Ligg</b>		Union Bridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC 22-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>PIPE CREEK</b>		22d. LOCATION (City, town, or county) <b>CARROLL CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartley &amp; Sons Union Bridge Md</b>		ADDRESS <b>12 W. 10th St. Philadelphia, Pa.</b>		24a. REC'D BY REGISTRAR <b>12/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. Powell, Esq.</b>	

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon fasteners. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

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LEADER V. 3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13129

## 13119 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>54 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>700 Rosemont Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>700 Rosemont Avenue</b>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>JOHN</b>	Middle <b>WESLEY</b>	Last <b>GROVE</b>	4. DATE OF DEATH <b>December 7, 1870</b>	Month <b>December</b>	Day <b>9</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>December 7, 1870</b>	9. AGE (in years (at birthday) <b>87</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hrs <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Developer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>David Grove</b>				14. MOTHER'S MAIDEN NAME <b>Marrietta Bopst</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>	17. INFORMANT <b>Mrs. Amy B. Grove—Same as item #1</b>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>321 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Frederick</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>Dec 7, 1957</i> to <i>Dec 9, 1957</i> , that I last saw the deceased alive on <i>Dec 9, 1957</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>East Church Street, Frederick, Maryland</i>								
DATE SIGNED <i>12/10/57</i>								
ACTUAL SIGNATURE <i>A. A. Pearre</i>								
PHYSICIAN'S NAME (Type) <b>Dr. A. A. Pearre</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Elizabeth B. Heck</b>		24b. REGISTRAR'S SIGNATURE		
VS A15 (4) ISM 9/55				DATE <b>10 Dec 1957</b>				

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13130

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Samuel</b>	Middle <b>J.</b>	Last <b>Huffer</b>	4. DATE OF DEATH <b>7 12 14 1957</b>	Month <b>July</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/28/1957</b>	9. AGE (In years last birthday) <b>89 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Huffer</b>		14. MOTHER'S MAIDEN NAME <b>Feba Huffer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT (If yes, give war or date of service) <b>/</b> Address <b>Austin Huffer, Middletown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		DUE TO <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Advanced Arteriosclerosis</b>		DUE TO <b>(c)</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1956, to <b>Dec 14</b> , 1957, that I last saw the deceased alive on <b>Dec 30</b> , 1957, and that death occurred at <b>1A</b> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Middletown</b>					
ACTUAL SIGNATURE <b>Elmer Harp</b>		DATE SIGNED <b>12-15-57</b>					
PHYSICIAN'S NAME (Type) <b>Elmer Harp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>8 Dec 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth L. Heck</b>			

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 2 and 3 should be filed with the record or prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILKINSON V. S.

250

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13131

13120

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Loudoun</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lovettsville-Rural-R.D.#1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>8-8-1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>E. A. Johnson</b>	First	Middle	Last	4. DATE OF DEATH <b>12 10 1957</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED #</b>	8. DATE OF BIRTH <b>February 4, 1861</b>	9. AGE (In years last birthday) <b>96</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel W. George</b>				14. MOTHER'S MAIDEN NAME <b>Estta Grubb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Miss Freada Johnson, Lovettsville, Virginia</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis with infarction of brain</b> DUE TO <b>3 days</b> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>10 years</b> (c) _____							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>12/7</b> , 1957, to <b>12/10</b> , 1957, that I last saw the deceased alive on <b>12/9</b> , 1957, and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>12/10/57</b>							
ACTUAL SIGNATURE <b>Henry V. Chase</b>	M.D.						
INTIMATE'S NAME (Type) <b>Henry V. Chase</b>	Frederick, Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 12, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) <b>Lovettsville, Maryland</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			ADDRESS	24a. REC'D BY REGISTRAR <b>Elizabeth G. Heck</b>	24b. REGISTRAR'S SIGNATURE		
				DATE <b>10 Dec 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUPERAU V. E.

DEC 19 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 20c Film MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
13144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13132  
131

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS							
Near Woodsboro		X2 Woodsboro		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH						
Male		White	WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	5. SEX	B. DATE OF BIRTH					
Mickey Mathew Keeney				1930 27 yrs.	6. COLOR OR RACE	9. AGE (In years last birthday)					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Driver truck		BOTTLING PLANT		Maryland		U.S.A					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address							
John Keeney		Helen Lass		Robert Keeney Frederick MD							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
Yes		218-24-2028		Helen Lass		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  929.9 Drowning accidental					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 4:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20g. DATE OF INJURY		20h. DATE OF DEATH		20i. DATE OF AUTOPSY		20j. DATE OF EXAMINATION		20k. DATE OF BURIAL		20l. DATE OF CREMATION	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. ACTUAL SIGNATURE		22b. EXAMINER'S NAME (Type)		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22d. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22e. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
B.C. Thomas		B.C. Thomas		M.D.		DATE SIGNED		December 27, 1957			
22f. BURIAL CREMATION REMOVAL (Specify)		22g. DATE THEREOF		22h. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22i. LOCATION (City, town, or county)		22j. DATE		(State)	
BURIAL		12/29/57		MT HOPE		WOODSBORO		Woodsboro		MD	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Powell & Hartzer Woodsboro Md		DATE DECEMBER 31 1957		Ely G. Kelly							

DUARDO V.

DEC 31 1957

11556

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13133

13121

## CERTIFICATE OF DEATH

Reg. Dist. No. 121

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-- Mt. Airy</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i>V.</i>	Last <i>Maisel</i>	4. DATE OF DEATH <i>12</i>	Month <i>12</i>	Day <i>24</i>	Year <i>1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3/18/75</i>	8. AGE (In years last birthday) <i>82 yrs.</i>	9. IF UNDER 1 YEAR Months <i>8</i>	10. IF UNDER 24 HRS Days <i>2</i>	11. Hours <i>0</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Ludwig Maisel</i>				14. MOTHER'S MAIDEN NAME <i>Annie V. Foreman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs. Dova Ecker,</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Hypertensive Cardiovascular Disease</i> 10 yrs + DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/23</i> , 1957, to <i>12/24</i> , 1957, that I last saw the deceased alive on <i>12/23</i> , 1957, and that death occurred at <i>12:45 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>12/24/57</i>							
ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D. <i>Henry V. Chase</i> M.D. <i>4 E. Church St</i> <i>12/24/57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-27-1957</i>		22c. NAME OF CEMETERY CEMETERY <i>Locust Grove Brethren, Frederick Co., Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz, Winfield, Md.</i>				24a. REC'D. BY REGISTRAR DATE <i>12/24/57</i>		24b. REGISTRAR'S SIGNATURE <i>E. G. Gandy</i>	

BUREAU X

EC 30 1957

REGELIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13134

13122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>14 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>419 Klinehart Alley</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Norma</b>		First <b>Norma</b>	Middle <b>Bell</b>
4. DATE OF DEATH <b>December 18 1894</b>		Lost <b>Marshall</b>	Month <b>December</b> Day <b>18</b> Year <b>1894</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>June 28, 1894</b>
9. AGE (In years, last birthday) <b>63 yrs.</b>		9. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hand Seiver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Toboring Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Ramsberg</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cline Rice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-9048</b> 17. INFORMANT Address <b>Raymond Cligan, Frederick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED <b>December 19, 1957</b>	
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	
22a. BURIAL CREMATION, ETC. REMOVAL (Specify) <b>Burial</b>		22d. LOCATION (City, town, or county) <b>Frederick</b> (State) <b>md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Barton</b>		24a. REC'D BY REGISTRAR DATE <b>23 Dec 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Hebb</b>	
VS. A15ME 5M 2 '57			

REED V. S.  
DEC 1957  
K-26-AV-6

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13135

13123

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>		c. LENGTH OF STAY IN lb <b>45 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>129 West Fifth Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>JOSEPH</b>	Middle <b>McDERMOTT</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 22, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron &amp; Steel Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3478</b>	17. INFORMANT Address <b>Mrs. L. William McCall, 407 Biggs Ave. Frederick, Md</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153 X</b>		INTERVAL BETWEEN ONSET AND DEATH <i>Carcinoma of Sigmoid</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO <i>Myocardial Decompenation</i>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension + Paraplegia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb</b> , 1949, to <b>Dec 26, 1957</b> , that I last saw the deceased alive on <b>Dec 26, 1957</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <b>East Second Street</b> DATE SIGNED <b>12/27/57</b>	
ACTUAL SIGNATURE <i>H. L. Fahrney</i>		PHYSICIAN'S NAME (Type) <b>Dr. H. L. Fahrney</b>	
22a. BURIAL, CREMATION, FURNAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 30, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE <b>30 Dec 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Herb</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the record prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNN V. S.

EC 21 1957

KEC

## 13145 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Braddock Heights</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Braddock Heights</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Ethel</b>	Middle <b>M.</b>	Last <b>Heehan</b>	4. DATE OF DEATH <b>Dec. 4th 1957</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26-1876</b>	9. AGE (In years last birthday) <b>81</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Benjamin Gregg</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine (Don't Know) Gregg</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Frances Latterell-Braddock Hgts.-Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia R.M. &amp; R.R.</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture right hip</b> DUE TO (c) <b>Fall (Possibly a pathological fracture &amp; then the fall)</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 days</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1957</b> to <b>1957</b> , that I last saw the deceased alive on <b>12/4 1957</b> , and that death occurred at <b>10:30PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>James B. Thomas</i>	M.D.		Professional Bldg.					
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>	Frederick-Maryland							
22a. BURIAL, CREMATION, REMAINT (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>12-9-1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>J. Wm. Lee's Crematory</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline &amp; Son</i>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>9 Dec 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>				

NUMBER V. 8

1950  
1950  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13146

## CERTIFICATE OF DEATH

13137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg.</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. # 2</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg,</b>		
d. STREET ADDRESS <b>R.D. #2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Maude</b>	First <b>Maude</b>	Middle <b>Manzella</b>	Last <b>Ohler</b>	
4. DATE OF DEATH <b>December 2, 1957</b>	Month <b>December</b>	Day <b>2</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1885</b>	
9. AGE (In years last birthday) <b>72</b>	10. IF UNDER 1 YEAR Months <b>72</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>George W. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Emma Jane Harbaugh</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Clyde Ohler</b>	Address <b>Emmitsburg, R.D. #2 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 44-000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>HYPERTENSIVE CARDIO-RENAL DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Emmitsburg</b>	(County) <b>Frederick Co.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>2 DECEMBER, 1957</b> to <b>2 DECEMBER, 1957</b> , that I last saw the deceased alive on <b>2 DECEMBER, 1957</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>FAIRFIELD, MARYLAND</b> DATE SIGNED <b>12/12/57</b>				
ACTUAL SIGNATURE <b>James H. Hammett MD</b>				
PHYSICIAN'S NAME (Type) <b>JAMES H. HAMMETT MD</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/5/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. View</b>	22d. LOCATION (City, town, or county) <b>Emmitsburg, Frederick Co. Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b> ADDRESS <b>Emmitsburg, Md.</b>				
24a. REC'D BY REGISTRAR DATE <b>DEC 5 '57</b> 24b. REGISTRAR'S SIGNATURE <b>John F. Smith</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

21-17-V.3

REC-144

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13138

## CERTIFICATE OF DEATH

131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE	
Frederick MARYLAND		Md.	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]		c. LENGTH OF STAY IN 1b c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]	
Frederick 16 hrs		Frederick	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION		d. STREET ADDRESS	
Frederick Mem.		118 East St	
3. NAME OF DECEASED (Type or print)		First	Middle
MARY Elizabeth Orem		First	Middle
4. DATE OF DEATH		Month	Day
Dec 30, 1957		Dec	31
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
F		C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec 30, 1957
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Clark Orem		Bessie Sheppard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Stolectisis	
762.5 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO			
(c)		Immaturity	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Dec. 1957</u> to <u>31 Dec. 1957</u> that I last saw the deceased alive on <u>31 Dec. 1957</u> , and that death occurred at <u>9:47 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		R. L. Guest M.D. J.E. Church St Frederick Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		1-4-58	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
FAIRVIEW		Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
C. E. Hicks II Frederick - Md.		24a. REC'D BY REGISTRAR DATE	
		JAN 8	
		Eug. Sh. 1/8	
20109394XV3			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. V. S.

1968

W. V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13147 CERTIFICATE OF DEATH

13139  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville		c. LENGTH OF STAY IN 1b 40 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First ANDERS	Middle PEARRE	Last	4. DATE OF DEATH DEC. 17, 1957	Month Dec.	Day 17	Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1884		9. AGE (in years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Calvin Anders		14. MOTHER'S M AIDEN NAME Anna Mary Repp							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Elmer Pittinger, Union Bridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary occlusion arteriosclerotic C.V.D.				INTERVAL BETWEEN ONSET AND DEATH suddenly			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. p. 19 p. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) New Windsor, Md.	(County)	(State)
21. I certify that I attended the deceased from alive on		3/11/56		19	to 12/17/57	19	that I last saw the deceased and that death occurred at 5:45 PM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state) New Windsor, Md.	
ACTUAL SIGNATURE M. E. Robertson M.D.								DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) M. E. Robertson M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-20-1957		22c. NAME OF CEMETERY OR CREMATORIAL Linganore		22d. LOCATION (City, town, or county) Unionville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE 12/17/57		24b. REGISTRAR'S SIGNATURE Ely Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUNNELL & CO

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13125 CERTIFICATE OF DEATH

13140

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Middletown		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice		First F.	Middle .	Last Remsberg	4. DATE OF DEATH 12	Month 21	Day Year 1957
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1883	9. AGE (In years longevity years) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sexton		10b. KIND OF BUSINESS OR INDUSTRY church		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Remsberg				14. MOTHER'S MAIDEN NAME Mahala Kefarver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elva Pepper, Princeton Jct., N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis with myocardial infarction</i>   INTERVAL BETWEEN 420.0   DUE TO <i>infarction</i>   ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under-   (b) <i>Anteriorislect heart disease</i>   10 days lying cause last.   (c)   5 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County)	(State)
21. I certify that I attended the deceased from <u>12/18</u> , 1957, to <u>12/21</u> , 1957, that I last saw the deceased alive on <u>12/20</u> , 1957, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Henry V Chase</i> M.D. <u>4 E. Church St</u> <u>12/31/57</u>							
22a. BURIAL, CREMATION, REMOVED (Specify) burial		22b. DATE THEREOF 12/24/1957	22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co.,		ADDRESS Middletown, Md.	24a. REC'D BY REGISTRAR DATE 26 Dec 1957		24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck		

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PERIODICALS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13141

13126

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> Lifetime		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 East 4th St.</b>		d. STREET ADDRESS <b>108 West 4th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Clayton Rowe</b>	First <b>James</b>	Middle <b>Clayton</b>	Last <b>Rowe</b>
4. DATE OF DEATH <b>December 13 1957</b>	Month <b>December</b>	Day <b>13</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-27-1874</b>
9. AGE (In years last birthday) <b>83 yr.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus Rowe</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Shroedel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-5526</b>	
17. INFORMANT <b>Mrs. Clarence R. Slack-31 E. 4th St. Frederick</b>		Address <b>Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 months	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO Arterio Sclerosis		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>Dec. 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 12</b> , 19 <b>57</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>12/14/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>		228 North Market Street -Frederick-Md.	
22a. BURIAL, CREMATION: REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>16 Dec 1957</b>	
ADDRESS <b>Frederick-Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Hebb</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUHLER V. E.

DEC 3 1971

11/1/71

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13142

## 13127 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>		d. STREET ADDRESS <b>Braddock</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>HENRY</b>	Middle <b>ALBERT</b>	Last <b>SCHUOLER</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>11</b>	Year <b>1957</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 June 1908</b>	9. AGE (in years last birthday) <b>49</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rural Mail Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Albert Schuoler</b>				14. MOTHER'S MAIDEN NAME <b>Anna Marie Schmidt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs., mo. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-34-5638</b>		17. INFORMANT <b>Mrs. Lulu Schuoler (Same as item #2)</b>		Address <b>111 1/2 Main St., Frederick, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frederick</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Stone</b> , 1938, to <b>Dec 11</b> , 1957, that I last saw the deceased alive on <b>Dec 11</b> , 1957, and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>17 E. 2nd St., Frederick, Md.</b>								
DATE SIGNED <b>12-12-57</b>								
ACTUAL SIGNATURE <b>H. Lawrence Fahrney</b>								
PHYSICIAN'S NAME (Type) <b>H. Lawrence Fahrney, M. D.</b>								
22a. BURIAL CREMATION, Specify <b>Burial</b>	22b. DATE THEREOF <b>12-13-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Elizabeth E. Heeb</b>		24b. REGISTRAR'S SIGNATURE		
				DATE <b>13 Dec 1957</b>				

WILHELM V. S.

DEC 12 1977

REFEVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13143

13148

## CERTIFICATE OF DEATH

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. LENGTH OF STAY IN 1b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		d. STREET ADDRESS <b>R.F.D. 2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 2</b>				d. STREET ADDRESS <b>R.F.D. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FRANK BAILEY</b>		First	Middle	Last	4. DATE OF DEATH <b>SHAFFAR</b>	Month <b>December</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 28, 1881</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpet layer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harry I. Shaffar</b>		14. MOTHER'S MAIDEN NAME <b>Frances Hill</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-28-8677</b>		17. INFORMANT <b>Edna Hoge Shaffar -R.F.D. 2, Mt. Airy</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Hypertension and arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Bronchitis, due to bronchial asthma</i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Bronchitis, due to bronchial asthma</i>						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>1955</b> , to <b>1957</b> , that I last saw the deceased alive on <b>Nov 23, 1957</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>W.B. Culwell</i>		M.D.				DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>W.B. Culwell</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/17/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar W. Wren</i>		ADDRESS <b>Ellsworth Armacost -4600 Liberty Hghts. Ave</b>		24a. REC'D BY REGISTRAR <b>12/17/1957</b>		24b. REGISTRAR'S SIGNATURE <i>Clarice Thunkle</i>		

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The blue copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13149 CERTIFICATE OF DEATH

13144  
131

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <input checked="" type="checkbox"/> (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (In this place)		STATE <input checked="" type="checkbox"/> (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Md. COUNTY Frederick (If rural give location)	
TOWN Braddock Heights		2 days		STREET ADDRESS		Rural Frederick Route 5	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vindobona Convalescent Home				/			
<b>3. NAME OF DECEASED</b> (First) <u>Henry</u> (Middle) <u></u> (Last) <u>Sines</u>				<b>4. DATE OF DEATH</b> (Month) <u>Dec</u> (Day) <u>11</u> (Year) <u>1957</u>			
5. SEX <input checked="" type="checkbox"/> Female	6. COLOR OR RACE <input checked="" type="checkbox"/> White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/> Married	8. DATE OF BIRTH <u>8/10/78</u>	9. AGE less birthday 79 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Deys <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Henry Hartsock</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Joseph W Sines, Frederick, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
49% IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arterio-sclerotic ulcers of feet</u> 9 months							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____			
21d. TIME OF INJURY (Month) <u>Dec</u> (Day) <u>11</u> (Year) <u>1957</u> (Hour) <u>3:30</u>		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>3/11</u>, 19<u>57</u>, to <u>12/11</u>, 19<u>57</u>, that I last saw the deceased alive on <u>12/11</u>, 19<u>57</u>, and that death occurred at <u>3:30</u> p. M., from the causes and on the date stated above.</b>							
SIGNATURE <u>J. R. Schowles</u> M. D. <u>22 P. M. Gladhill Frederick</u> 12/11/57 ADDRESS (Street, city, town, state) _____ DATE SIGNED _____							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/14/1957</u>		NAME OF CEMETERY OR CREMATORIUM <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) <u>Middletown, Md.</u> (State) _____	
24. REC'D BY REGISTRAR DATE <u>14 Dec 1957</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gladhill Co., Middletown, Md.</u>			

1. A. 00000

2. C.

3. A. 00000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13:28

## CERTIFICATE OF DEATH

13145  
931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>4 wks.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine, Maryland</b>		d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mrs. Mary A. Slagle</b>	First	Middle	Last	4. DATE OF DEATH <b>Dec. 11, 1957</b>	Month	Day	Year		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1903</b>	9. AGE (In years last birthday) <b>54</b> yr.	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS Days <b>1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William W. Pickett</b>		14. MOTHER'S MAIDEN NAME <b>Annie C. Hargett</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles Slagle, Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>175X</b> <i>Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Carcinoma left ovary</b>		(b) <i>Carcinoma left ovary</i>		(c)					
DUE TO		DUE TO		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County)	(State)
21. I certify that I attended the deceased from <b>11 Dec. 1957</b> to <b>7 Dec. 1957</b> , that I last saw the deceased alive on <b>7 Dec. 1957</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b>									
DATE SIGNED <b>Dec. 1957</b>									
ACTUAL SIGNATURE <b>Robert H. Pilgram</b>		PHYSICIAN'S NAME (Type) <b>Robert H. Pilgram</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-10-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Ely N. Schick</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13146

13150

## CERTIFICATE OF DEATH

Reg. Dist. No. 115

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 51 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) Meade		First Garfield	Middle Smith
4. DATE OF DEATH December 17		Month 1957	Day Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 10, 1880
9. AGE (In years lost birthday) 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Labor	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sameul Smith		14. MOTHER'S MAIDEN NAME Barbara Toms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Annie Smith, Myersville, Md. Rt. #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Second	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 14</u> , 1957, to <u>Dec 17</u> , 1957, that I last saw the deceased alive on <u>Dec 14</u> , 1957, and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Middletown DATE SIGNED 12-17-57	
ACTUAL SIGNATURE J Elmer Harp M.D.		PHYSICIAN'S NAME (Type) J Elmer Harp	
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		22b. DATE THEREOF 12-20-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Walk U.B.		22d. LOCATION (City, town, or county) Nr. Myersville, Fred. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Bittle		ADDRESS Paul E. Bittle, Myersville, Md.	
24a. REC'D BY REGISTRAR DATE 12-18-57		24b. REGISTRAR'S SIGNATURE Fay M. Bittle	

January 1981

DEC

RECORDED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13151 CERTIFICATE OF DEATH

13147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Blue Ridge Summit</b>		c. LENGTH OF STAY IN 1b <b>30 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Blue Ridge Summit</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Laertes</b>	Middle <b>Pittman</b>	Last <b>Springs</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>15,</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1891</b>
9. AGE (In years from birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Diplomatic Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Winston Salem N. C.</b>	
10c. BIRTHPLACE (State or foreign country) <b>Winston Salem N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Springs</b>		14. MOTHER'S MAIDEN NAME <b>Bobo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War 1</b>	
17. INFORMANT <b>Mrs. Marjory Fraser Springs, Blue Ridge Summit Pa</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <b>30 Minutes</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Dec.</b> , 1957, to <b>15 Dec.</b> , 1957, that I last saw the deceased alive on <b>15 Dec.</b> , 1957, and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert A. Lufkin</i> ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa.</b> DATE SIGNED <b>15 Dec. 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Y. Grove Waynesboro Pa</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '57</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. L. couch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000 V. S.

DEC

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13148

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

13:52

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KNOXVILLE</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X: KNOXVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. #1</b>		d. STREET ADDRESS <b>R.F.D. #1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>- WILLIAM</b>	Last <b>- TURNER</b>
4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>26</b>	Year <b>1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 26, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad LINEMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY TURNER</b>	14. MOTHER'S MAIDEN NAME <b>HATTIE CASTLE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO	17. INFORMANT <b>MRS. J. W. TURNER</b>	Address <b>KNOXVILLE Md.</b>
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Cerebrovascular accident Tobacco & alcohol abuse			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9-1-1957</b> to <b>12-26-1957</b> , that I last saw the deceased alive on <b>12-26-1957</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brownsville, Md.</b> DATE SIGNED <b>12-26-57</b>			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) <b>John W. Turner M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-28-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>BROWNSVILLE</b>	22d. LOCATION (City, town, or county) <b>BROWNSVILLE</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer J. Feltz Brunswick Md.</b>	ADDRESS <b>Elmer J. Feltz Brunswick Md.</b>	24a. REC'D BY REGISTRAR DATE <b>12-29-57</b>	24b. REGISTRAR'S SIGNATURE <b>Eugenia L. Bush</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

СУДАУ В. С

DEC

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give tags 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its appointed agent, prior to burial, cremation, or removal, and in any event within 72 hours after

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13149

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wolfsville</i>	c. LENGTH OF STAY IN 16 <i>50 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wolfsville</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF  (Type or print)	First <i>Margaret</i>	Middle <i>Elizabeth</i>	Last <i>Haarenfeltz</i>	4. DATE OF DEATH <i>December 20 1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 11, 1896</i>	9. AGE (In years from birthday) <i>61</i> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>	11. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	12. IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
13. FATHER'S NAME <i>Jacob B.</i>	14. MOTHER'S MARRIED NAME <i>Miller</i>	Hannah (?)	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>npne</i>	17. INFORMANT <i>Charles E. Haarenfeltz</i>	Address <i>Wolfsville Rd</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>
DUE TO Conditions, if any, which gave rise to immediate cause (b) <i> </i>
DUE TO (c) <i> </i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (c)
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Greensburg</i>	(County) <i>Md.</i>
(State) <i> </i>					

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE <i>B.O. Thomas</i>	EXAMINER'S NAME (Type) <i>B.O. Thomas</i>	MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <i>December 20 1957</i>
22a. BURIAL Cremation <input type="checkbox"/> REMOVED <input type="checkbox"/> burial <input checked="" type="checkbox"/>	22b. DATE THEREOF <i>12/23/1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Welty's Cemetery</i>	22d. LOCATION (City, town, or county) <i>Greensburg</i> , (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co., Middletown, Md.</i>	ADDRESS <i> </i>	24a. REC'D BY REGISTRAR <i>Elizabeth L. Heck</i>	24b. REGISTRAR'S SIGNATURE <i> </i>
DATE 26 Dec 1957			

BEREAU V.

DEC 27 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 13150  
**13151 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Emmitsburg,</b>		c. LENGTH OF STAY IN lb <b>50 years</b>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Emmitsburg,</b>		d. STREET ADDRESS <b>17 West Main Street</b>	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <b>17 West Main Street</b>				d. STREET ADDRESS <b>17 West Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Bernard</b>	Last <b>Welty</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 21, 1867</b>	9. AGE [In years last birthday] <b>90</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Welty</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Hobbs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elmer W. Leinich</b>		Address <b>17 West Main St. Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b> DUE TO <b>402.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Fracture</b> (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture inferior &amp; superior ramus right pubis</b>							
19. WAS AUTOPSY PERFORMED? <b>NO</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <b>Fracture inferior &amp; superior ramus right pubis</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/9</b> , 1955, to <b>12/25</b> , 1957, that I last saw the deceased alive on <b>12/24</b> , 1957, and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emmitsburg, Md.</b> DATE SIGNED <b>Dec. 26, 1957</b>							
ACTUAL SIGNATURE <b>Charles R Williams</b> M.D.							
PHYSICIAN'S NAME (Type) <b>CHARLES R Williams</b> <b>Emmitsburg, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Joseph's Catholic</b>		22d. LOCATION (City, town, or county) <b>Emmitsburg, Frederick Co., Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>		ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 30 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Aut. by</b>	

BURKE V. S

DEC 30 195

REGREVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13151

13155

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. STREET ADDRESS <i>X? Walkersville</i>	
3. NAME OF DECEASED (Type or print) <i>MINNIE Frock</i>		First <i>W</i>	Middle <i>WINEBRENNER</i>
4. DATE OF DEATH <i>Dec 26 1957</i>		Month <i>Dec</i>	Day <i>26</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 22 1868</i>		9. AGE (In years lost birthday) <i>89 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. IF UNDER 24 HRS Days <i>—</i>	13. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
14. MOTHER'S MAIDEN NAME <i>Laura Jane Martin</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. James Stover, Walkersville, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease</i> DUE TO <i>440.8</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 50</i> , 1950, to <i>26 Dec</i> , 1957, that I last saw the deceased alive on <i>25 Dec</i> , 1957, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. Stover, Jr.</i> PHYSICIAN'S NAME (Type) <i>JAMES E. STOVER, Jr.</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i> DATE SIGNED <i>26 Dec 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 29, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oak Hill Cemetery</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		24a. ADDRESS <i>Walkersville, Md.</i>	24b. REC'D BY REGISTRAR DATE <i>28 Dec 1957</i>
24c. REGISTRAR'S SIGNATURE <i>Elizabeth B. Heek</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THEORY, S.

DEC 5, 1957

KEG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13129 CERTIFICATE OF DEATH

Reg. Dist. No.

13152

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>MINUTES</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AGNES LORETTA YINGLING</b>		First	Middle
		Last	
4. DATE OF DEATH <b>DEC. 14</b>		Month	Day
		Year	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/28/1907</b>		9. AGE (In years lost birthday) <b>49</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>WINFIELD S. GRIMES</b>	
14. MOTHER'S MAIDEN NAME <b>GERTRUDE HINSWORTH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NON</b>		17. INFORMANT <b>J.H. YINGLING</b>	Address <b>NEW WINDSOR, MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Arterio Sclerotic C-V disease</b>		years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260. Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 13</b> , 1957, to <b>Dec 14</b> , 1957, that I last saw the deceased alive on <b>Dec 13</b> , 1957, and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>105 E MAIN ST</b> Baltimore, MD	
ACTUAL SIGNATURE <b>James T. Marsh</b>		DATE SIGNED <b>12-14-57</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rocky Hill CEM.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Butler &amp; Sons New Windsor, Md.</b>		22d. LOCATION (City, town, or county) <b>Woodsboro Rural MD.</b>	(State)
		24a. REC'D BY REGISTRAR <b>Elisabeth B. Heis</b>	24b. REGISTRAR'S SIGNATURE
		DATE <b>18 Dec 1957</b>	

DEPARTMENT OF DEFENSE - DIVISION OF INFORMATION

CERTIFICATE OF DEATH

BUREAU X. E

DEC 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13:30

## CERTIFICATE OF DEATH

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131

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown-Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>Della</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOSEPH</b>	Middle <b>RICHARD</b>	Last <b>YOUNG</b>	4. DATE OF DEATH <b>December 27, 1957</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3 Aug. 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Hillery Young</b>		14. MOTHER'S MAIDEN NAME <b>Fannie F. Riggs</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lewis A. Young, RFD, Adamstown, Md.</b>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Appendical abscess with rupture</b> 3 weeks DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis right upper lobe, active.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002x</b>			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>4 B. Church St., Frederick, Md.</b>	(County) <b>Frederick County</b> (State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Dec 8</b> , 1957, to <b>Dec 27</b> , 1957, that I last saw the deceased alive on <b>Dec 27</b> , 1957, and that death occurred at <b>2:25 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 B. Church St., Frederick, Md.</b> DATE SIGNED <b>12-28-57</b>					
ACTUAL SIGNATURE <i>Henry V. Chase</i>	PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-31-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Della Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick County Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			ADDRESS	24a. REC'D BY REGISTRAR DATE <b>31 Dec 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1955

RECEIVED